STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00116211. Complaint IN00116211 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309. Survey dates: October 9 & 10, 2012 Facility number: 000012 Provider number: 155029 AIM number: 100274900 Survey team: Christi Davidson, RN-TC Lora Brettnacher, RN Census bed type: SNF/NF: 104 Total: 104 Census payor type: Medicare: 15 Medicaid: 80 Other: 9 Total: 104 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review 10/15/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify a physician and a resident's family of emesis and loose stools, and the facility failed to notify the physician	F0157	**F157 Notify of changes** This provider ensures the resident, resident's physician and	10/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	when the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not limited to, history of multiple cerebral vascular accidents, dementia, hypertension, diabetes, contractures and history of pneumonia. The most recent Minimum Data Set [MDS] Assessment dated 08/05/12 indicated Resident #B had no speech and was severely cognitively impaired. The MDS assessment indicated Resident #B needed extensive assist with two person physical assist with activities of daily living and had impairment to both upper and lower extremities on one side. A care plan dated 6/15/12 indicated, "...severely impaired decision making skills...Anticipate resident's needs...Check on resident every two hours or as needed...."		resident's legal representative or an interested family member will be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident no longer resides in this facility. Corrective action/staff education on notification of changes, change in condition and code status for staff member caring for Resident B. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have a change in condition have the potential to be affected by the alleged deficient practice. · Audit change of condition residents for appropriate notification. Corrective action for all deficiencies up to and including termination. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan dated 6/15/12 indicated, "Resident has chosen to be a do not resuscitate status...CPR [cardio pulmonary resuscitation] will not be initiate (sic) if resident is found not breathing or is not responsive...." A recapitulation dated 08-01-2012 through 08-31-2012 with a physician's order dated 06/08/12 indicated, "...DNR [do not resuscitate]...." A physician's order, untimed and dated 8/26/12, indicated, "May send to E.R. [emergency room] to eval [evaluate] and treat...." A facility emergency resident transfer form dated 8/26/12 indicated Resident #B was transferred to the hospital at 9:55 a.m. An ambulance run sheet dated 8/26/12 at 0943 [9:43 a.m.] indicated, "...RN reports pt [patient] condition has deteriorated since 2300 the previous night. Pt does not respond to verbal or painful stimuli and makes only grunts when given a sternal rub...." A progress note dated 8/15/12 at 2:55 a.m. indicated, "...non-verbal able to use gestures and shake head for yes and no to express self...."		**recur?** · Staff education on change of condition, notification of changes and code status by 10/26/2012 by the Director of Nursing Services and/or designee. · All nursing staff were educated by the Staff Development Coordinator by 10/26/12 on the difference between Hospice and a DNR Code Status. Education included that all residents with DNR code status are to receive the same response as any other resident in change of condition, other than cardio pulmonary arrest, unless otherwise indicated in Advance Directive. Education included that residents on Hospice Services will have a Care Plan in place that has been determined by resident, family, physician, and hospice services on medical treatment during a change of condition other than cardio pulmonary arrest. · Daily review by Director of Nursing Services and/or designee of documentation on residents including those receiving Hospice services and those with a DNR code status who have a change of condition for appropriate notification and documentation. · Road to Recovery meetings to include review of change of condition. · Corrective action for deficiencies up to and including termination. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A progress note dated 8/23/12 at 3:20 a.m. indicated, "...Resting quietly...Alert to self and non-verbal, no acute distress noted...." A progress note dated 8/23/12 at 2:46 p.m. indicated, "Up in chair for breakfast. Ate well. Had large amount of emesis x [times] one after breakfast. Went back to bed. No further emesis this shift." A charting document dated 8/23/12 indicated physician and family notification at 5:00 p.m. for emesis. A progress note dated 8/25/12 at 9:30 p.m., indicated, "[Recorded as Late Entry on 09/07/2012 08:41 PM]...CNA [certified nursing assistant] reported to this writer that res [resident] had emesis and loose stools while they were giving him a shower. Res also noted with emesis x 1 while in bed. Res's bottom lip noted with dried blood to lower lip...." A progress note dated 8/26/12 at 7:32 a.m., indicated, "...unable to arouse. res had emesis on evening shift x 3. res had a temp of 100.8, res given tylenol for temp and it went down. res in bed at this time. MD [medical doctor] informed. awaiting call back		**assurance program will be put into place?** · Change of Condition CQI will be utilized weekly X4 then monthly thereafter for atleast 6 months. · Results of the audits will be submitted to the CQI Committee for review and follow up. Action plan will be developed for compliance < 90%. Corrective action up to and including termination for issues identified. **Compliance date: 10/26/2012**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at this time." A progress note dated 8/26/12 at 8:00 a.m. indicated, "MD returned phone call back to the facility...Due to the resident being a DNR, MD wanted to known (sic) if the family wanted him sent to the hospital...." A progress note dated 8/26/12 at 8:05 a.m. indicated, "Attempted to contact resident's family concerning condition. No answer. Left voicemail. Awaiting return phone call." A progress note dated 8/26/12 at 9:30 a.m. indicated, "Resident lying in bed unable to arouse...Respirations even and unlabored...Resident laying in bed with eyes closed...Family notified again. Family requested that resident be sent out to the hospital. Order obtained to send to E.R. to eval and treat." A progress note dated 09/07/12 at 3:45 p.m. indicated, "...Daughter had concerns regarding resident being sent out to the hospital...Daughter asked about resident's episodes of emesis, including dates, MD notification...Discussed communication regarding change in resident's condition; nursing had attempted to notify her and was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unable to reach her upon noting unresponsiveness and notifying MD. On second attempt to notify her, she decided to have resident sent out to hospital but was upset that facility did not do this sooner. DON [Director of Nursing] explained that resident has DNR code status and that per her request he was sent out but that otherwise DNR protocol would have been to make resident comfortable...." The record lacked documentation of physician or family notification regarding Resident #B's emesis and loose stools recorded in progress notes on 8/25/12. The record lacked documentation of physician and family notification of Resident #B's emesis three times from evening shift 8/25/12 recorded in the progress notes on 8/26/12. The record lacked documentation of physician notification when Resident #B's family could not be reached at 8:05 a.m. on 8/16/12 after his significant change in level of consciousness. During an interview on 10/9/12 at 2:40 p.m., the DoN indicated the physician and Resident #B's family were not notified of the emesis or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	loose stools on 8/25/12. During an interview on 10/10/12 at 10:45 a.m., Resident #B's attending physician indicated she was informed on 8/26/12 Resident #B did not open his eyes. She indicated she was only informed of one episode of emesis. She indicated the facility was to call the family to see if they wanted Resident #B sent to the emergency room and call the physician back. A facility policy titled, "Resident Change of Condition," and revised 3/10 indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs....Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and /or acute care evaluation...." This Federal tag relates to Complaint IN00116211. 3.1-5(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to do a thorough neurological assessment, obtain a blood sugar by performing an accucheck or obtain frequent vital signs for a resident with a significant change in level of consciousness. The facility also failed to follow up with the attending physician for one hour and 25 minutes when the resident's family could not be reached for 1 of 5 residents reviewed for resident assessment and care. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not limited to, history of multiple cerebral vascular accidents, dementia, hypertension, diabetes, contractures and history of pneumonia. The most recent Minimum Data Set [MDS] Assessment dated 08/05/12	F0309	**F309 Provide care/services for highest well being.** It is the practice of this provider to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident no longer resides in this facility. Corrective action/staff education on notification of changes, change in condition and code status for staff member caring for Resident B. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident #B had no speech and was severely cognitively impaired. The MDS assessment indicated Resident #B needed extensive assist with two person physical assist with activities of daily living and had impairment to both upper and lower extremities on one side. A care plan dated 6/15/12 indicated, "...severely impaired decision making skills...Anticipate resident's needs...Check on resident every two hours or as needed...." A care plan dated 6/15/12 indicated, "Resident has chosen to be a do not resuscitate status...CPR [cardio pulmonary resuscitation] will not be initiate (sic) if resident is found not breathing or is not responsive...." A care plan dated 6/27/12 indicated, "Resident is at risk...of hyperglycemia or hypoglycemia related to...diagnosis of diabetes mellitus...." A recapitulation dated 08-01-2012 through 08-31-2012 with a physician's order dated 06/08/12 indicated, "...DNR [do not resuscitate]...." A recapitulation dated 08-01-2012 through 08-31-2012 with a physician's		**taken?** · Residents who have a change in condition have the potential to be affected by the alleged deficient practice. · Audit change of condition residents for appropriate assessment and notification. Corrective action for all deficiencies up to and including termination. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Staff education on change of condition, notification of changes and code status by 10/26/2012 by the Director of Nursing Services and/or designee. · Staff education on change in mental status; assessment to include neuro check. Diabetic change in condition; assessment to include accu check. · Daily review by Director of Nursing Services and/or designee of documentation on residents including those receiving Hospice services and those with a DNR code status who have a change of condition for appropriate notification and documentation. · Corrective action for deficiencies up to and including termination. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Change of Condition CQI will be utilized weekly X4 then monthly thereafter for atleast 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order dated 06/28/12 indicated, "Accucheck twice daily 2 times weekly on Monday and Thursday - Call Blood Sugar [sign for less than] 70 or [sign for greater than] 301...." A medication administration record dated 08-01-2012 through 08-31-2012 indicated the most recent accucheck for Resident #B was recorded on 8/23/12. A physician's order, untimed and dated 8/26/12, indicated, "May send to E.R. [emergency room] to eval [evaluate] and treat...." A facility emergency resident transfer form dated 8/26/12 indicated Resident #B was transferred to the hospital at 9:55 a.m. An ambulance run sheet dated 8/26/12 at 0943 [9:43 a.m.] indicated, "...RN reports pt [patient] condition has deteriorated since 2300 the previous night. Pt does not respond to verbal or painful stimuli and makes only grunts when given a sternal rub...Blood sugar: 256...." A hospital record dated 8/26/12 indicated, "...Acute intra-cranial hemorrhage Neurosurgery declined intervention. Family reported to ER a		months. · Results of the audits will be submitted to the CQI Committee for review and follow up. Action plan will be completed for compliance < 90%. Corrective action up to and including termination for issues identified. **Compliance date: 10/26/2012**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	no code status...Little to offer with such a massive blled (sic) and herniation. Pt unlikely to survive beyond hours or a few days...." Review of progress notes indicated the following: A progress note dated 8/15/12 at 2:55 a.m. indicated, "...non-verbal able to use gestures and shake head for yes and no to express self...." A progress note dated 8/23/12 at 3:20 a.m. indicated, "...Resting quietly...Alert to self and non-verbal, no acute distress noted...." A progress note dated 8/23/12 at 2:46 p.m. indicated, "Up in chair for breakfast. Ate well. Had large amount of emesis x [times] one after breakfast. Went back to bed. No further emesis this shift. A progress note dated 8/25/12 at 9:30 p.m., indicated, "[Recorded as Late Entry on 09/07/2012 08:41 PM]...CNA [certified nursing assistant] reported to this writer that res [resident] had emesis and loose stools while they were giving him a shower. Res also noted with emesis x 1 while in bed. Res's bottom lip noted with dried blood to lower lip...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility matrix vital sign tracking document indicated Resident #B's vital signs on 8/25/12 at 9:37 p.m. were blood pressure 167/88, respirations 20 per minute, pulse 91 per minute and temperature 98.9 degrees Fahrenheit. A progress note dated 8/26/12 at 7:32 a.m., indicated, "...unable to arouse. res had emesis on evening shift x 3. res had a temp of 100.8, res given tylenol for temp and it went down. res in bed at this time. MD [medical doctor] informed. awaiting call back at this time." A facility matrix vital sign tracking document indicated Resident #B's vital signs on 8/26/12 at 7:30 a.m. were blood pressure 170/90, respirations 18 per minute, pulse 91 per minute and temperature 100.8 degrees Fahrenheit. A progress note dated 8/26/12 at 8:00 a.m. indicated, "MD returned phone call back to the facility...Due to the resident being a DNR, MD wanted to known (sic) if the family wanted him sent to the hospital...." A progress note dated 8/26/12 at 8:05 a.m. indicated, "Attempted to contact resident's family concerning condition.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	No answer. Left voicemail. Awaiting return phone call." A progress note dated 8/26/12 at 9:30 a.m. indicated, "Resident lying in bed unable to arouse...Respirations even and unlabored...Resident laying in bed with eyes closed...Family notified again. Family requested that resident be sent out to the hospital. Order obtained to send to E.R. to eval and treat." A facility matrix vital sign tracking document indicated Resident #B's vital signs on 8/26/12 at 9:30 a.m. were pulse 68 per minute. A facility matrix vital sign tracking document indicated Resident #B's vital signs on 8/26/12 at 10:00 a.m. were blood pressure 167/84, Respirations 22 per minute and temperature 99.1 degrees Fahrenheit. A progress note dated 09/07/12 at 3:45 p.m. indicated, "...Daughter had concerns regarding resident being sent out to the hospital...Daughter asked about resident's episodes of emesis, including dates, MD notification...Discussed communication regarding change in resident's condition; nursing had attempted to notify her and was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unable to reach her upon noting unresponsiveness and notifying MD. On second attempt to notify her, she decided to have resident sent out to hospital but was upset that facility did not do this sooner. DON [Director of Nursing] explained that resident has DNR code status and that per her request he was sent out but that otherwise DNR protocol would have been to make resident comfortable...." During an interview on 10/9/12 at 10:05 a.m., the ADoN indicated if a resident had a change in condition a full assessment of the resident should be done, including vital signs, check the body, check for edema, and check for any changes. During an interview on 10/09/12 at 2:40 p.m., the DoN indicated if a resident was a DNR and had a change in condition other than pulmonary or cardiac, for example, unarousable, the nurse should notify the physician and provide comfort measures if the resident's vital signs are stable. During an interview on 10/10/12 at 8:55 a.m., the DoN indicated neurological checks were a part of vital signs. The DoN indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	neurological checks were not performed on Resident #B. The DoN was asked if a blood sugar was performed on 8/26/12 due to Resident #B's history of diabetes and the change in level of consciousness. During an interview on 10/10/12 at 10:45 a.m., Resident #B's attending physician indicated she was informed on 8/26/12 that Resident #B was not opening his eyes. She indicated she instructed the facility to reach the family to see if they wanted Resident #B sent to the emergency room and to call her back. She indicated a DNR does not mean not to treat. She indicated when she did hear back from the facility, they indicated the family wanted the resident sent to the emergency room; therefore, she gave the telephone order to send Resident #B to the emergency room. As of exit on 10/10/12 at 3:30 p.m. no further documentation was provided for an accucheck, full neurological assessment or additional vital sign assessment from 8/26/12 at 7:30 a.m. until 8/26/12 at 9:30 a.m. after a level of consciousness change for Resident #B was recognized by the nursing staff. A facility policy titled, "Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Change of Condition," and revised 3/10 indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs....Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and /or acute care evaluation...." This Federal tag relates to Complaint IN00116211. 3.1-37(a)			